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Patient Name: _____ Date: _____ **Dr. Gary Olson| Patient Health Intake**

Describe your symptoms: _____

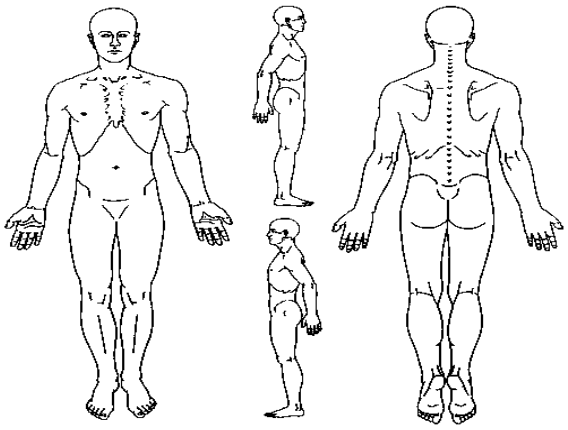
How did your symptoms begin: _____

When did your symptoms begin: _____

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Burning ☐ Dull ache
- ☐ Numb ☐ Tingling

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

During the past 4 weeks:

Indicate the average intensity of your symptoms:

None									*Unbearable*
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How much has pain interfered with your daily activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In general would you say your overall health right now is…

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms?

☐ Chiropractor ☐ Medical doctor ☐ Physical therapy ☐ Other ☐ No one

What treatment did you receive and when? _____

What tests have you had for your symptoms, and when were they performed?

☐ X-rays *date*: _____ ☐ MRI *date*: _____

☐ CT Scan *date*: _____ ☐ Other *date*: _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ Chiropractor ☐ Medical doctor ☐ Other ☐ Physical therapy ☐ No one

What is your occupation? _____

☐ Professional/Executive ☐ Laborer ☐ Retired ☐ Other
☐ White Collar/Secretarial ☐ Homemaker ☐ Tradesperson ☐ Student

If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employment ☐ Off work
☐ Part-time ☐ Unemployment ☐ Other

Please mark all of the following that apply to you:

- ☐ Alcohol-Drug dependence
- ☐ Recent fever
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke (*date*) _____
- ☐ Corticosteroid use (Cortisone, Prednisone, etc.)
- ☐ Taking birth control pills
- ☐ Dizziness/Fainting
- ☐ Numbness in groin/Buttocks
- ☐ Cancer/Tumor (*explain*) _____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Prostate problems
- ☐ Menstrual problems
- ☐ Urinary problems
- ☐ Currently pregnant, # Weeks _____
- ☐ Abnormal weight Gain Loss
- ☐ Marked morning pain/stiffness
- ☐ Pain unrelieved by position or rest
- ☐ Pain at night
- ☐ Visual disturbances
- ☐ Tobacco use, type/frequency _____
- ☐ Medications _____

☐ Other health problems (*explain*) _____

Family History: ☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Heart problems/Stroke ☐ Rheumatoid arthritis

What aggravates this condition? _____

What decreases the symptoms/pain? _____

In what position do you sleep? ☐ Back ☐ Side ☐ Stomach

Do you sleep with a pillow? ☐ Yes ☐ No How many? _____

Does heat affect the pain? ☐ Yes ☐ No If so, how? _____

Does cold affect the pain? ☐ Yes ☐ No If so, how? _____

Do you wear a heel lift? ☐ Yes ☐ No If so, which side? ☐ Right ☐ Left

How long can you sit with no pain or minimal pain? _____ minutes.

How long can you stand with no or minimal pain? _____ minutes.

How far can you walk with no or minimal pain?

☐ 0-50 ft. ☐ 50-200 ft. ☐ 200-500 ft. ☐ 500+ ft. ☐ ½ mile+

Do you require support to help you walk from a cane or a walker? ☐ Yes ☐ No

Do you wear a neck or back brace? ☐ Yes ☐ No

Surgical History

Procedure	Year	Doctor's name	Comments

Patient/Guardian Signature: _____ Date: _____